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NOTES

OMA DISCUSSION PAPER: *PRIMARY CARE REFORM*

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In February 1996, the Ontario Medical Association's Primary Care Reform Group, chaired by Dr. Wendy Graham, released a draft discussion paper on primary care reform, specifically on a new way to pay primary care physicians (general and family practitioners -- GP/FPs). [1] It was published in the context of a global cap on physicians' OHIP billings, threats of strike action by some doctors and negotiations on physician funding between the OMA and the Ministry of Health. This discussion paper is of particular interest because it marks the acceptance by the Association of the basic principle of a threshold on physician billings.

Summary

The paper proposes a new model of "Reformed Fee-for-Service" payment for GP/FPs who want to sign on to such a program; the paper does not recommend that all primary care practitioners would be shifted to such a system. Under it:

- patients would sign on to the roster of a specific family practice;
- the practice would provide 24-hour service;
- patients would be expected to receive all their care with this practice, unless they were referred elsewhere;
- patients could change rosters up to twice a year (i.e. could be on three different rosters) with a six-week commitment;
- patients receiving non-emergency care outside the practice would be billed for that care (alternative arrangements would be made if an individual was out of town);
- physicians would be paid an agreed amount for each person on their roster for standard care, to be adjusted by age, sex and chronic illness;
- additional specified services (obstetrical, house calls, emergency room work, etc.) could be billed separately by these physicians; and
- an income cap would be set for these physicians.

The paper argues that such a system would:

- avoid duplication of services
- create efficient referrals (since rostered patients would no longer be able to go to specialists unless they were referred by their regular physician);
- constrain patients from self-referral, double-doctoring, etc.;
- promote continuity of care, which tends to improve care; and
- address the geographical distribution of physicians.

[1] Primary Care Reform Physician Advisory Group, *Primary Care Reform: A Strategy for Stability, (Draft 6)* (Toronto: Ontario Medical Association, February 1996).

Though the few press articles on the paper were mainly descriptive, specific problems with the proposal were noted.

- It introduces the possibility that people could pay for non-emergency but medically necessary services if they receive them from someone other than their rostered physician. This would appear to violate the *Canada Health Act.*
- The paper does not define the kind of care that must be available 24 hours a day.
- It limits the ability of patients to get a second opinion.
- Doctor-shopping may not be as costly a problem as the report assumes.
- Duplication of care could be resolved in other ways, while the mechanism for addressing shortages of doctors is not clear.[2]

The paper was endorsed by the governing council of the OMA in late February.

Ministry Committee

The most important response to the paper was the July announcement by the Ministry of Health that Dr. Graham of the OMA group had been appointed chair of a Ministry primary care reform implementation committee.

Her committee is to help the Ministry pilot and evaluate two new models of primary health care delivery: one funded via capitation and one using reformed fee-for-service. Under capitation, a physician or group practice is paid a fixed sum for each patient on the practice roster; in most jurisdictions, this fixed amount will vary by the age, gender and general health of the patients. The reformed fee-for-service pilot, as described in the Ministry's announcement, seems to follow the model proposed in the OMA paper quite closely. Both types of practice would be expected to provide: 24-hour care; basic health promotion; basic diagnosis and illness care; maternal, labour and delivery, and newborn care; and referrals to specialists. Patients will not be assigned to a roster but may choose a practice; they will then enter a contractual commitment for at least six weeks.

The Ministry announcement does not make clear in its description of the two models whether the patient would be expected to pay for non-emergency care received elsewhere, as the OMA paper recommends.

The committee is to make recommendations on:

- patient rostering and physician funding;
- defining the services to be provided and developing performance measures for them;
- a strategy for quality maintenance and provider education;
- issues related to risk management, use of information, and monitoring and evaluating effectiveness;
- developing a plan to market the reforms to providers and consumers;
- criteria in selecting pilot sites; and
- an evaluation plan.

As of this writing (1 October 1996), the committee has not yet announced pilot sites for the reforms.

[2] Mark Kennedy, "OMA ponders cash register medicine," *Ottawa Citizen*, 23 February 1996, p. A4; "Wrong prescription," *Ottawa Citizen*, 29 February 1996, p. A12.

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